DEPARTMENT OF PUBLIC HEALTH
CLINICAL LABORATORY PROGRAM
305 South Street, Jamaica Plain, MA 02130
(617) 983-6739 fax (617) 983-6740

I. APPLICATION INFORMATION

Name: _____

Address: _____
Street City State Zip code

Telephone: _____ Contact Person: _____

CLIA #: _____ Certificate Type: _____

II. SCREENING PROGRAM INFORMATION

A.) Location type (check all that apply)

☐ Permanent/Fixed (complete section III) ☐ Temporary/Mobile (complete section IV)

B.) Facility or company which will provide final disposal of the holder's special medical waste:

Name: _____

Address: _____
Street City State Zip code

Telephone: _____

C.) Licensed laboratory where specimens will be sent semi-annually to verify test accuracy:

Name: _____

Address: _____
Street City State Zip code

Telephone: _____ Contact Person: _____

III. PERMANENT/FIXED SCREENING PROGRAM

A.) Location (address) of Screening Program

B.) Schedule of Operation

	Days of Week	Time (Hours)
_____	_____	_____
_____	_____	_____
_____	_____	_____

C.) Test procedure (check all that apply)

	TEST	METHOD/ANALYZER
☐	CHOLESTEROL [Capillary Whole Blood]	_____
☐	ERYTHROCYTE PROTOPORPHYRIN [Capillary Whole Blood]	_____
☐	FECAL OCCULT BLOOD	_____
☐	HEMOGLOBIN [Capillary Whole Blood]	_____
☐	HEMATOCRIT [Capillary Whole Blood]	_____
☐	HDL CHOLESTEROL [Capillary Whole Blood]	_____
☐	GLUCOSE [Capillary Whole Blood]	_____
☐	PREGNANCY TEST, QUALITATIVE	_____

D.) Briefly state the purpose for offering the test(s) checked above.

_____

_____

_____

_____

Signature of Authorized Individual _____

Title: _____

Date: _____

Telephone: _____

IV. TEMPORARY/MOBILE SCREENING PROGRAM

Please complete a separate application for each site where the screening program is offered and return to the above address at least 5 days prior to each screening event. PLEASE MAKE COPIES AS NECESSARY.

APPLICANT NAME: _____

A.) Location (address) of Screening Program

B.) Schedule of Operation

	Days of Week	Time (Hours)
_____	_____	_____
_____	_____	_____
_____	_____	_____

C.) Test procedure (check all that apply)

	TEST	METHOD/ANALYZER
☐	CHOLESTEROL [Capillary Whole Blood]	_____
☐	ERYTHROCYTE PROTOPORPHYRIN [Capillary Whole Blood]	_____
☐	FECAL OCCULT BLOOD	_____
☐	HEMOGLOBIN [Capillary Whole Blood]	_____
☐	HEMATOCRIT [Capillary Whole Blood]	_____
☐	HDL CHOLESTEROL [Capillary Whole Blood]	_____
☐	GLUCOSE [Capillary Whole Blood]	_____
☐	PREGNANCY TEST, QUALITATIVE	_____

D.) Briefly state the purpose for offering the test(s) checked above.

_____

_____

_____

_____

Signature of Authorized Individual _____

Title: _____

Date: _____

Telephone: _____

The Health Promotion Screening application packet must contain all of the following documents/forms.

- ☐ Health Screening Promotion application – completed and signed
- ☐ CLIA application – completed and signed [if the facility does not already have a current certificate]
- ☐ Procedure for performing test(s) [see item 1]
- ☐ Calibration procedure and documentation form [see items 2 and 5]
- ☐ Quality control procedure and documentation form [see items 4 and 5]
- ☐ Patient test report form and educational materials [see item 6]
- ☐ Training records [see item 8]